Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
METROPOLITAN FAMILY PRACTICE

Respondent Name
STATE OFFICE OF RISK MANAGEMENT

MFDR Tracking Number
M4-11-3504-01

Carrier's Austin Representative
Box Number 45

MFDR Date Received
JUNE 13, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "SERVICES DEEMED MEDICALLY NECESSARY"

Amount in Dispute: $1,239.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Office performed an in-depth review of the dispute packet submitted by the Metropolitan Family Practice, and will maintain its denial for ANSI code 50-Services not deemed medically necessary and W12 – Extent of Injury not finally adjudicated. In review of Dr. Shaw's letter of medical necessity it states that the injured worker was being seen for medication management, the Office determined upon completion of an in-depth review of our claim file the injured worker had not received medications for her workers' compensation injury since 5/2/2007. The medical records submitted unfortunately are not legible for the Office to determine what actually the injured worker was being seen for to determine if the visit was related to her worker's compensation injury. Review of the medications listed on Dr. Shaw's medical records indicate that she was filling medication for her pre-existing health conditions and not directly related to her workers' compensation injury. Furthermore, The Office respectfully requests the Division deem this dispute not eligible for review as it has been determined that the provider did not submit the medical fee dispute in accordance with Rule §133.307(c)(1)(A)."

Response Submitted by: State Office of Risk Management

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 16, 2008 September 30, 2008 October 29, 2008 December 15, 2008 January 15, 2009 February 16, 2009 March 16, 2009	CPT Code 99213 – Office Visit CPT Code 99080-73 – Work Status Report	$125.00/date X7 = $875.00	$0.00
November 14, 2008	CPT Code 99214 – Office Visit CPT Code 20552- Trigger Point Injection(s) HCPCS Code J2001- Lidocaine HCI CPT Code 99080-73 – Work Status Report	$364.00	$0.00
TOTAL		$1,239.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.305 sets forth general provisions regarding dispute of medical bills.
2. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
3. 28 Texas Administrative Code §133.308 sets out the procedures for health care providers to pursue a medical necessity dispute.
4. 28 Texas Administrative Code §141.1 sets out the procedures for requesting and setting a Benefit Review Conference.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - November 14, 2008: W12-Extent of injury not finally adjudicated.
   - December 15, 2008: 50-Services not deemed 'Medically Necessary' by payer
   - Neither party to the dispute submitted explanation of benefits for the remaining disputed dates of service.

Issues

1. Did the requestor waive the right to medical fee dispute resolution for dates of service July 16, 2008, September 30, 2008, October 29, 2008, January 15, 2009, February 16, 2009 and March 16, 2009?
2. Did the requestor file for medical fee dispute resolution in accordance with 28 Texas Administrative Code §133.305 and §133.307?
3. Is the requestor eligible for medical fee dispute resolution under 28 Texas Administrative Code §133.307?

Findings

1. 28 Texas Administrative Code §133.307(c)(1) states: "Timeliness. A requestor shall timely file with the Division's MDR Section or waive the right to MDR. The Division shall deem a request to be filed on the date the MDR Section receives the request.
   A) A request for medical fee dispute resolution that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute.
   B) A request may be filed later than one year after the date(s) of service if:
   (i) a related compensability, extent of injury, or liability dispute under Labor Code Chapter 410 has been filed, the medical fee dispute shall be filed not later than 60 days after the date the requestor receives the final decision, inclusive of all appeals, on compensability, extent of injury, or liability;

   (ii) a medical dispute regarding medical necessity has been filed, the medical fee dispute must be filed not later than 60 days after the date the requestor received the final decision on medical necessity, inclusive of all appeals, related to the health care in dispute and for which the carrier previously denied payment based on medical necessity."

   The dates of service in dispute are July 16, 2008 through March 16, 2009. The request for medical dispute resolution was received in the Medical Dispute Resolution (MDR) section on June 13, 2011. These dates are later than one year after the date(s) of service in dispute. Review of the submitted documentation finds that the disputed services rendered on July 16, 2008, September 30, 2008, October 29, 2008, January 15, 2009, February 16, 2009 and March 16, 2009 do not involve issues identified in §133.307, subparagraph (B). The Division concludes that the requestor has failed to timely file this dispute with the Division's MDR Section; consequently, the requestor has waived the right to medical fee dispute resolution for dates of service July 16, 2008, September 30, 2008, October 29, 2008, January 15, 2009, February 16, 2009 and March 16, 2009.

2. According to 28 Texas Administrative Code §133.305(a)(4), a medical fee dispute as a dispute that involves an amount of payment for non-network health care rendered to an injured employee (employee) that has been determined to be medically necessary and appropriate for treatment of that employee's compensable injury." 28 Texas Administrative Code §133.305(b) goes on to state that "If a dispute regarding compensability, extent of injury, liability, or medical necessity exists for the same service for which there is a medical fee dispute, the disputes regarding compensability, extent of injury, liability or medical necessity shall be resolved prior to the submission of a medical fee dispute for the same services in accordance with Labor Code §413.031 and 408.021."

   The respondent denied reimbursement for services rendered on December 15, 2008 based upon not being

medically necessary. The appropriate dispute process for unresolved issues of medical necessity are addressed in 28 Texas Administrative Code §133.308. No documentation was submitted to support that the issue(s) of medical necessity have been resolved as of the undersigned date.

The respondent denied reimbursement for services rendered on November 14, 2008 based upon extent of injury. The appropriate dispute process for unresolved issues of compensability, extent and/or liability requires filing for a Benefit Review Conference pursuant to 28 Texas Administrative Code §141.1 prior to requesting medical fee dispute resolution. No documentation was submitted to support that the issue(s) of compensability, extent and/or liability have been resolved as of the undersigned date.

3. The requestor has failed to support that the disputed services are eligible for medical fee dispute resolution pursuant to 28 Texas Administrative Code §133.307.

Conclusion

The Division finds that the requestor has waived the right to medical fee dispute resolution for the services in dispute. For that reason, the merits of the issues raised by both parties to this dispute have not been addressed.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	06/13/2014 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.